

104TH CONGRESS
1ST SESSION

H. R. 1912

To deter and penalize health care fraud and abuse and to simplify the
administration of health benefit plans.

IN THE HOUSE OF REPRESENTATIVES

JUNE 22, 1995

Mr. STARK introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To deter and penalize health care fraud and abuse and
to simplify the administration of health benefit plans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Care Fraud Prevention and Paperwork Reduction
6 Act of 1995”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings.

Sec. 3. Inapplicability of McCarran-Ferguson Act.

Sec. 4. Definitions.

TITLE I—FRAUD AND ABUSE

Subtitle A—Amendments to Anti-Fraud and Abuse Provisions Applicable to Medicare, Medicaid, and State Health Care Programs

Sec. 101. Anti-kickback statutory provisions.

Sec. 102. Civil money penalties.

Sec. 103. Private right of action.

Sec. 104. Amendments to exclusionary provisions in fraud and abuse program.

Sec. 105. Sanctions against practitioners and persons for failure to comply with statutory obligations relating to quality of care.

Sec. 106. Revisions to criminal penalties.

Sec. 107. Effective date.

Subtitle B—Establishment of All-Payer Health Care Fraud and Abuse Control Program

Sec. 111. All-payer health care fraud and abuse control program.

Sec. 112. Establishment of all-payer health care fraud and abuse control account.

Subtitle C—Application of Fraud and Abuse Authorities Under the Social Security Act to Other Payers

Sec. 121. Application of civil money penalties to all payers.

Sec. 122. Application of certain criminal penalties to all payers.

Sec. 123. Construction of social security act references.

Subtitle D—Advisory Opinions on Kickbacks and Self-Referral

Sec. 131. Establishment of process for issuance of advisory opinions.

Sec. 132. Imposition of fees.

Subtitle E—Preemption of State Corporate Practice Laws

Sec. 141. Preemption of State laws prohibiting corporate practice of medicine.

TITLE II—INFORMATION SYSTEMS AND ADMINISTRATIVE SIMPLIFICATION

Sec. 201. Requirement for health benefit cards.

Sec. 202. National enrollment verification system.

Sec. 203. Requirements for uniform claims and electronic claims data set.

Sec. 204. Reporting of uniform clinical data sets.

Sec. 205. Uniform hospital cost reporting.

Sec. 206. Use of task forces.

1 **SEC. 2. FINDINGS.**

2 The Congress finds as follows:

3 (1) The costs of health care consume more than
4 14 percent of the gross domestic product of the

1 United States, significantly affecting interstate com-
2 merce and the budget of the Federal Government.

3 (2) Federal outlays for the medicare program
4 alone totaled \$162,500,000,000 in fiscal year 1994
5 and are expected to exceed \$177,000,000,000 in fis-
6 cal year 1995 and \$198,000,000,000 in fiscal year
7 1996.

8 (3) According to the General Accounting Office,
9 as much as 10 percent of all health care expendi-
10 tures in the United States, or \$100,000,000,000, is
11 lost each year to health care fraud and abuse.

12 (4) As a direct provider of health care and as
13 a source of payment for health care, the Federal
14 Government has a significant interest in assessing
15 the quality and costs of health care through the eval-
16 uative activities of several Federal agencies.

17 (5) The health care system existing throughout
18 the United States has a significant effect on the
19 amount, distribution, and use of Federal funds be-
20 cause of the large numbers of—

21 (A) individuals who receive health care
22 benefits under programs operated or financed
23 in whole or in part by the Federal Government;

24 (B) individuals who benefit because of the
25 exclusion from Federal taxes of the amounts

1 spent by their employers to provide them with
2 health insurance benefits;

3 (C) health care providers and professionals
4 who provide items and services for which the
5 Federal Government makes payments; and

6 (D) health care providers and professionals
7 who have received direct or indirect financial
8 assistance from the Federal Government be-
9 cause of their status as such a provider or pro-
10 fessional.

11 (6) It is in the interest of the United States
12 that there be a national “all-payer” anti-fraud pro-
13 gram, and a national administrative simplification
14 program, for our health care industry.

15 **SEC. 3. INAPPLICABILITY OF MCCARRAN-FERGUSON ACT.**

16 For purposes of section 2(b) of the Act of March 9,
17 1945 (15 U.S.C. 1012(b); commonly known as the
18 McCarran-Ferguson Act), this Act shall be considered to
19 specifically relate to the business of insurance.

20 **SEC. 4. DEFINITIONS.**

21 For purposes of this Act:

22 (1) CARRIER.—The term “carrier” means a li-
23 censed insurance company, a hospital or medical
24 service corporation (including an existing Blue Cross
25 or Blue Shield organization, within the meaning of

1 section 833(c)(2) of the Internal Revenue Code of
2 1986), a health maintenance organization, or other
3 entity licensed or certified by a State to provide
4 health insurance or health benefits. The Secretary
5 may issue regulations that provide for affiliated car-
6 riers to be treated as a single carrier where appro-
7 priate under this title.

8 (2) HEALTH BENEFIT PLAN.—

9 (A) IN GENERAL.—The term “health bene-
10 fit plan” means—

11 (i) a health plan, other than a plan
12 described in subparagraph (B);

13 (ii) the medicare program;

14 (ii) medicare supplemental health in-
15 surance;

16 (iii) the medicaid program; and

17 (iv) except as the Secretary may pro-
18 vide, other Federal or State programs that
19 provide for payments for health care serv-
20 ices (other than coverage or insurance de-
21 scribed in subparagraph (B)).

22 (B) EXCEPTION.—The term “health bene-
23 fit plan” does not include any of the following
24 (or any combination thereof):

1 (i) Coverage only for accident, dental,
2 vision, disability income, or long-term care
3 insurance, or any combination thereof.

4 (ii) Coverage issued as a supplement
5 to liability insurance.

6 (iii) Liability insurance, including gen-
7 eral liability insurance and automobile li-
8 ability insurance.

9 (iv) Worker's compensation or similar
10 insurance.

11 (v) Automobile medical-payment in-
12 surance.

13 (vi) Coverage for a specified disease
14 or illness.

15 (vii) A hospital or fixed indemnity pol-
16 icy.

17 (3) HEALTH BENEFIT PLAN SPONSOR.—The
18 term “health benefit plan sponsor” means, in rela-
19 tion to a health benefit plan that—

20 (A) is an insured plan, the carrier provid-
21 ing the plan; or

22 (B) is a self-insured plan, the entity that
23 sponsors the plan (as defined by the Secretary).

24 (4) HEALTH CARE PROVIDER.—The term
25 “health care provider” includes a provider of services

1 (as defined in section 1861(u) of the Social Security
2 Act), a physician, a laboratory (as defined in section
3 353(a) of the Public Health Service Act), a supplier,
4 and any other person furnishing health care in a
5 State. Such term includes a Federal or State pro-
6 gram that provides directly for the provision of
7 health care to beneficiaries.

8 (5) HEALTH PLAN.—The term “health plan”
9 means—

10 (A) any contract of health insurance, in-
11 cluding any hospital or medical service policy or
12 certificate, hospital or medical service plan con-
13 tract, or health maintenance organization group
14 contract, that is provided by a carrier in a
15 State; or

16 (B) an employee welfare benefit plan or
17 other arrangement insofar as the plan or ar-
18 rangement provides health benefits in a State
19 and is funded in a manner other than through
20 the purchase of one or more policies or con-
21 tracts described in subparagraph (A).

22 (6) MANAGED CARE PLAN.—The term “man-
23 aged care plan” means a health plan that provides
24 for items and services covered under the plan pri-

1 marily through providers in the provider network of
2 the plan.

3 (7) POINT-OF-SERVICE PLAN.—The term
4 “point-of-service plan” means a health plan other
5 than a managed care plan that permits an enrollee
6 to receive benefits through a provider network.

7 (8) PROVIDER NETWORK.—The term “provider
8 network” means, with respect to a health plan, pro-
9 viders who have entered into an agreement with the
10 plan under which such providers are obligated to
11 provide items and services covered under the plan to
12 individuals enrolled in the plan.

13 (9) SECRETARY.—The term “Secretary” means
14 the Secretary of Health and Human Services.

15 (10) SELF-INSURED.—The term “self-insured”
16 means, with respect to a health plan, a plan that is
17 described in paragraph (5)(B).

18 (11) STATE.—The term “State” means the 50
19 States, the District of Columbia, Puerto Rico, the
20 Virgin Islands, Guam, the Northern Mariana Is-
21 lands, and American Samoa.

1 **TITLE I—FRAUD AND ABUSE**
2 **Subtitle A—Amendments to Anti-**
3 **Fraud and Abuse Provisions Ap-**
4 **plicable to Medicare, Medicaid,**
5 **and State Health Care Programs**

6 **SEC. 101. ANTI-KICKBACK STATUTORY PROVISIONS.**

7 (a) REVISION TO PENALTIES.—

8 (1) PERMITTING SECRETARY TO IMPOSE CIVIL
9 MONETARY PENALTY.—Section 1128A(a) of the So-
10 cial Security Act (42 U.S.C. 1320a–7a(a)) is amend-
11 ed—

12 (A) by striking “or” at the end of para-
13 graphs (1) and (2);

14 (B) by striking the semicolon at the end of
15 paragraph (3) and inserting “; or”; and

16 (C) by inserting after paragraph (3) the
17 following new paragraph:

18 “(4) carries out any activity in violation of
19 paragraph (1) or (2) of section 1128B(b);”.

20 (2) DESCRIPTION OF CIVIL MONETARY PEN-
21 ALTY APPLICABLE.—Section 1128A(a) of such Act
22 (42 U.S.C. 1320a–7a(a)) is amended—

23 (A) by striking “given).” at the end of the
24 first sentence and inserting the following:

1 “given or, in cases under paragraph (4),
2 \$50,000 for each such violation).”; and

3 (B) by striking “claim.” at the end of the
4 second sentence and inserting the following:
5 “claim (or, in cases under paragraph (4), dam-
6 ages of not more than three times the total
7 amount of remuneration offered, paid, solicited,
8 or received.”.

9 (3) INCREASE IN CRIMINAL PENALTY.—Para-
10 graphs (1) and (2) of section 1128B(b) of such Act
11 (42 U.S.C. 1320a–7b(b)) are each amended—

12 (A) by striking “\$25,000” and inserting
13 “\$50,000”; and

14 (B) by striking the period at the end and
15 inserting the following: “, and shall be subject
16 to damages of not more than three times the
17 total remuneration offered, paid, solicited, or
18 received.”.

19 (b) REVISIONS TO EXCEPTIONS.—

20 (1) EXCEPTION FOR DISCOUNTS.—Section
21 1128B(b)(3)(A) of such Act (42 U.S.C. 1320a–
22 7b(b)(3)(A)) is amended by striking “program;” and
23 inserting “program and is not in the form of a cash
24 payment;”.

1 (2) EXCEPTION FOR PAYMENTS TO EMPLOY-
2 EES.—Section 1128B(b)(3)(B) of such Act (42
3 U.S.C. 1320a–7b(b)(3)(B)) is amended by inserting
4 at the end “if the amount of remuneration under the
5 arrangement is consistent with the fair market value
6 of the services and is not determined in a manner
7 that takes into account (directly or indirectly) the
8 volume or value of any referrals, except that such
9 employee can be paid remuneration in the form of
10 a productivity bonus based on services personally
11 performed by the employee.”.

12 (3) EXCEPTION FOR WAIVER OF COINSURANCE
13 BY CERTAIN PROVIDERS.—Section 1128B(b)(3)(D)
14 of such Act (42 U.S.C. 1320a–7b(b)(3)(D)) is
15 amended to read as follows:

16 “(D) a waiver or reduction of any coinsurance
17 or other copayment if—

18 “(i) the waiver or reduction is made pursu-
19 ant to a public schedule of discounts which the
20 person is obligated as a matter of law to apply
21 to certain individuals,

22 “(ii) the waiver or reduction is made pur-
23 suant to an established program and applies to
24 a defined group of individuals whose incomes do
25 not exceed 150 percent (or such higher percent-

1 age as the Secretary may permit) of the official
2 poverty line (as defined by the Office of Man-
3 agement and Budget, and revised annually in
4 accordance with section 673(2) of the Omnibus
5 Budget Reconciliation Act of 1981) applicable
6 to a family of the size involved,

7 “(iii) the waiver or reduction of coinsur-
8 ance is not offered as part of any advertisement
9 or solicitation and the person offering the waiv-
10 er or reduction determines in good faith that
11 the individual is in financial need,

12 “(iv) the person offering the waiver or re-
13 duction fails to collect the coinsurance or other
14 payment after making reasonable collection ef-
15 forts, or

16 “(v) the waiver or reduction of coinsurance
17 is in accordance with a cost sharing schedule or
18 a supplemental benefit package which may be
19 offered by a managed care plan (as defined in
20 section 4 of the Health Care Fraud Prevention
21 and Paperwork Reduction Act of 1995); and”.

22 (4) NEW EXCEPTION FOR CAPITATED PAY-
23 MENTS.—Section 1128B(b)(3) of such Act (42
24 U.S.C. 1320a–7b(b)(3)) is amended—

1 (A) by striking “and” at the end of sub-
2 paragraph (D);

3 (B) by striking the period at the end of
4 subparagraph (E) and inserting “; and”; and

5 (C) by adding at the end the following new
6 subparagraphs:

7 “(F) any reduction in cost sharing or increased
8 benefits given to an individual, any amounts paid to
9 a provider for an item or service furnished to an in-
10 dividual, or any discount or reduction in price given
11 by the provider for such an item or service, if the
12 individual is enrolled with and such item or service
13 is covered under any of the following:

14 “(i) A health plan which is furnishing
15 items or services under a risk-sharing contract
16 under section 1876 or section 1903(m).

17 “(ii) A health plan receiving payments on
18 a prepaid basis, under a demonstration project
19 under section 402(a) of the Social Security
20 Amendments of 1967 or under section 222(a)
21 of the Social Security Amendments of 1972;
22 and

23 “(G) any amounts paid to a provider for an
24 item or service furnished to an individual or any dis-
25 count or reduction in price given by the provider for

1 such an item or service, if the individual is enrolled
2 with and such item or service is covered under a
3 health plan under which the provider furnishing the
4 item or service is paid by the health plan for fur-
5 nishing the item or service only on a capitated basis
6 pursuant to a written arrangement between the plan
7 and the provider in which the provider assumes fi-
8 nancial risk for furnishing the item or service.”.

9 (c) AUTHORIZATION FOR THE SECRETARY TO ISSUE
10 REGULATIONS.—Section 1128B(b) of such Act (42 U.S.C.
11 1320a–7b(b)) is amended by adding at the end the follow-
12 ing new paragraph:

13 “(4) The Secretary is authorized to impose by regula-
14 tion such other requirements as needed to protect against
15 program or patient abuse with respect to any of the excep-
16 tions described in paragraph (3).”.

17 (d) CLARIFICATION OF OTHER ELEMENTS OF OF-
18 FENSE.—Section 1128B(b) of such Act (42 U.S.C.
19 1320a–7b(b)) is amended—

20 (1) in paragraph (1)(A), by striking “in return
21 for referring” and inserting “to refer”;

22 (2) in paragraph (1)(B), by striking “in return
23 for purchasing, leasing, ordering, or arranging for or
24 recommending” and inserting “to purchase, lease,
25 order, or arrange for or recommend”; and

1 (3) by adding at the end of paragraphs (1) and
2 (2) the following sentence: “A violation exists under
3 this paragraph if one or more purposes of the remun-
4 eration is unlawful under this paragraph.”.

5 **SEC. 102. CIVIL MONEY PENALTIES.**

6 (a) PROHIBITION AGAINST OFFERING INDUCEMENTS
7 TO INDIVIDUALS ENROLLED UNDER PLANS.—

8 (1) OFFER OF REMUNERATION.—Section
9 1128A(a) of the Social Security Act (42 U.S.C.
10 1320a–7a(a)), as amended by section 101(a)(1), is
11 amended—

12 (A) by striking “; or” at the end of para-
13 graph (3) and inserting a semicolon;

14 (B) by striking the semicolon at the end of
15 paragraph (4) and inserting “; or”; and

16 (C) by inserting after paragraph (4) the
17 following new paragraph:

18 “(5) offers, pays, or transfers remuneration to
19 any individual eligible for benefits under title XVIII
20 of this Act, or under a State health care program
21 (as defined in section 1128(h)) that such person
22 knows or should know is likely to influence such in-
23 dividual to order or receive from a particular pro-
24 vider, practitioner, or supplier any item or service
25 for which payment may be made, in whole or in

1 part, under title XVIII, or a State health care pro-
2 gram, other than to influence an individual enrolled
3 in a managed care plan or a point-of-service plan (as
4 defined in section 4 of the Health Care Fraud Pre-
5 vention and Paperwork Reduction Act of 1995 to re-
6 ceive benefits under the plan in accordance with es-
7 tablished practice patterns for the delivery of medi-
8 cally necessary services;”.

9 (2) REMUNERATION DEFINED.—Section
10 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is
11 amended by adding at the end the following new
12 paragraph:

13 “(6) The term ‘remuneration’ includes the waiv-
14 er or reduction of coinsurance amounts, and trans-
15 fers of items or services for free or for other than
16 fair market value, except that such term does not in-
17 clude the waiver or reduction of coinsurance
18 amounts by a person or entity, if—

19 “(A) the waiver or reduction is made pur-
20 suant to a public schedule of discounts which
21 the person is obligated as a matter of law to
22 apply to certain individuals,

23 “(B) the waiver or reduction is made pur-
24 suant to an established program and applies to
25 a defined group of individuals whose incomes do

1 not exceed 150 percent (or such higher percent-
2 age as the Secretary may permit) of the official
3 poverty line (as defined by the Office of Man-
4 agement and Budget, and revised annually in
5 accordance with section 673(2) of the Omnibus
6 Budget Reconciliation Act of 1981) applicable
7 to a family of the size involved,

8 “(C) the waiver or reduction of coinsur-
9 ance is not offered as part of any advertisement
10 or solicitation and the person offering the waiv-
11 er or reduction determines in good faith that
12 the individual is in financial need,

13 “(D) the person offering the waiver or re-
14 duction fails to collect the coinsurance or other
15 payment after making reasonable collection ef-
16 forts, or

17 “(E) the waiver or reduction of coinsur-
18 ance is in accordance with a cost sharing sched-
19 ule or a supplemental benefit package which
20 may be offered by a managed care plan under
21 section 4 of the Health Care Fraud Prevention
22 and Paperwork Reduction Act of 1995.”.

23 (b) ADDITIONAL OFFENSES.—Section 1128A(a) of
24 such Act, as amended by section 101(a)(1) and subsection
25 (a)(1), is further amended—

1 (1) by striking “or” at the end of paragraph
2 (4);

3 (2) by striking the semicolon at the end of
4 paragraph (5) and inserting “; or”; and

5 (3) by inserting after paragraph (5) the follow-
6 ing new paragraphs:

7 “(6) engages in a practice which has the effect
8 of limiting or discouraging (as compared to other
9 plan enrollees) the utilization of medically necessary
10 health care services covered by law or under the
11 service contract by title XIX or other publicly sub-
12 sidized patients, including but not limited to dif-
13 ferential standards for the location and hours of
14 service offered by providers participating in the plan;

15 “(7) substantially fails to cooperate with a qual-
16 ity assurance program or a utilization review activ-
17 ity;

18 “(8) engaging in a pattern of failing substan-
19 tially to provide or authorize medically necessary
20 items and services that are required to be provided
21 to an individual covered under a health plan (as de-
22 fined in section 4 of the Health Care Fraud Preven-
23 tion and Paperwork Reduction Act of 1995) or pub-
24 lic program for the delivery of or payment for health
25 care items or services, if the failure has adversely af-

1 fected (or had a substantial likelihood of adversely
2 affecting) the individual; or

3 “(9) submits false or fraudulent statements,
4 data or information on claims to the Secretary, a
5 State health care agency, or any other Federal,
6 State or local agency charged with implementation
7 or oversight of a health plan or a public program
8 that the person knows or should know is fraudu-
9 lent;”.

10 (c) MODIFICATIONS OF AMOUNTS OF PENALTIES
11 AND ASSESSMENTS.—Section 1128A(a) of such Act (42
12 U.S.C. 1320a–7a(a)), as amended by section 101(a), sub-
13 section (a)(1), and subsection (b), is amended in the mat-
14 ter following paragraph (9)—

15 (1) by striking “\$2,000” and inserting
16 “\$10,000”;

17 (2) by inserting after “under paragraph (4),
18 \$50,000 for each such violation” the following: “; in
19 cases under paragraph (5), \$10,000 for each such
20 offer, payment, or transfer; in cases under para-
21 graphs (6) through (9), an amount not to exceed
22 \$10,000 for each such determination by the Sec-
23 retary”; and

24 (3) by striking “twice the amount” and insert-
25 ing “three times the amount”.

1 (d) INTEREST ON PENALTIES.—Section 1128A(f) of
2 such Act (42 U.S.C. 1320a–7a(f)) is amended by adding
3 after the first sentence the following: “Interest shall ac-
4 crue on the penalties and assessments imposed by a final
5 determination of the Secretary in accordance with an an-
6 nual rate established by the Secretary under the Federal
7 Claims Collection Act. The rate of interest charged shall
8 be the rate in effect on the date the determination becomes
9 final and shall remain fixed at that rate until the entire
10 amount due is paid. In addition, the Secretary is author-
11 ized to recover the costs of collection in any case where
12 the penalties and assessments are not paid within 30 days
13 after the determination becomes final, or in the case of
14 a compromised amount, where payments are more than
15 90 days past due. In lieu of actual costs, the Secretary
16 is authorized to impose a charge of up to 10 percent of
17 the amount of penalties and assessments owed to cover
18 the costs of collection.”.

19 (e) AUTHORIZATION TO ACT.—

20 (1) IN GENERAL.—The first sentence of section
21 1128A(c)(1) of such Act (42 U.S.C. 1320a–
22 7a(c)(1)) is amended by striking all that follows
23 “(b)” and inserting the following: “unless, within
24 one year after the date the Secretary presents a case
25 to the Attorney General for consideration, the Attor-

1 ney General brings an action in a district court of
2 the United States.”.

3 (2) EFFECTIVE DATE.—The amendment made
4 by this paragraph (1) shall apply to cases presented
5 by the Secretary of Health and Human Services for
6 consideration on or after the date of the enactment
7 of this Act.

8 (f) DEPOSIT OF PENALTIES COLLECTED INTO ALL-
9 PAYER ACCOUNT.—Section 1128A(f)(3) of such Act (42
10 U.S.C. 1320a–7a(f)(3)) is amended by striking “as mis-
11 cellaneous receipts of the Treasury of the United States”
12 and inserting “in the All-Payer Health Care Fraud and
13 Abuse Control Account established under section 112 of
14 the Health Care Fraud Prevention and Paperwork Reduc-
15 tion Act of 1995”.

16 (g) CLARIFICATION OF PENALTY IMPOSED ON EX-
17 CLUDED PROVIDER FURNISHING SERVICES.—Section
18 1128A(a)(1)(D) of such Act (42 U.S.C. 1320a–
19 7a(a)(1)(D)) is amended by inserting “who furnished the
20 service” after “in which the person”.

21 **SEC. 103. PRIVATE RIGHT OF ACTION.**

22 Section 1128A of the Social Security Act (42 U.S.C.
23 1320a–7a) is amended by adding at the end the following
24 new subsection:

1 “(m)(1) Subject to paragraphs (2) and (3), a carrier
2 offering an insured health plan and the sponsor of a self-
3 insured health plan that suffers financial harm as a direct
4 result of the submission of claims by an individual or en-
5 tity for payment for items and services furnished under
6 the plan which makes the individual or entity subject to
7 a civil monetary penalty under this section may, in a civil
8 action against the individual or entity in the United States
9 District Court, obtain damages against the individual or
10 entity and such equitable relief as is appropriate.

11 “(2) A carrier or sponsor may bring a civil action
12 under this subsection only if the carrier or sponsor pro-
13 vides the Secretary and the Attorney General with written
14 notice of the intent to bring an action under this sub-
15 section, the identities of the individuals or entities the car-
16 rier or sponsor intends to name as defendants to the ac-
17 tion, and all information the carrier or sponsor possesses
18 regarding the activity that is the subject of the action that
19 may materially affect the Secretary’s decision to initiate
20 a proceeding to impose a civil monetary penalty under this
21 section against the defendants.

22 “(3) A carrier or sponsor may bring a civil action
23 under this subsection only if any of the following condi-
24 tions are met:

1 “(A) During the 60-day period that begins on
2 the date the Secretary receives the written notice de-
3 scribed in paragraph (2), the Secretary does not no-
4 tify the carrier or sponsor that the Secretary intends
5 to initiate a proceeding to impose a civil monetary
6 penalty under this section against the defendants.

7 “(B) If the Secretary notifies the carrier or
8 sponsor during the 60-day period described in sub-
9 paragraph (A) that the Secretary intends to initiate
10 a proceeding to impose a civil monetary penalty
11 under this section against the defendants, the Sec-
12 retary subsequently notifies the carrier or sponsor
13 that the Secretary no longer intends to initiate such
14 a proceeding against the defendants.

15 “(C) After the expiration of the 2-year period
16 that begins on the date the Secretary notifies the
17 carrier or sponsor that the Secretary intends to initi-
18 ate a proceeding to impose a civil monetary penalty
19 under this section against the defendants, the Sec-
20 retary has not made a good faith effort to initiate
21 such a proceeding against the defendants.

22 “(4) If a carrier or sponsor is awarded any amounts
23 in an action brought under this subsection that are in ex-
24 cess of the damages suffered by the carrier or sponsor as
25 a result of the defendant’s activities, 10 percent of such

1 amounts shall be withheld from the carrier or sponsor for
2 payment into the All-Payer Health Care Fraud and Abuse
3 Control Account established under section 112 of the
4 Health Care Fraud Prevention and Paperwork Reduction
5 Act of 1995.

6 “(5) No action may be brought under this subsection
7 more than 6 years after the date of the activity with re-
8 spect to which the action is brought.”.

9 **SEC. 104. AMENDMENTS TO EXCLUSIONARY PROVISIONS IN**
10 **FRAUD AND ABUSE PROGRAM.**

11 (a) MANDATORY EXCLUSION OF INDIVIDUAL CON-
12 VICTED OF CRIMINAL OFFENSE RELATED TO HEALTH
13 CARE FRAUD.—

14 (1) IN GENERAL.—Section 1128(a) of the So-
15 cial Security Act (42 U.S.C. 1320a–7(a)) is amend-
16 ed by adding at the end the following new para-
17 graph:

18 “(3) FELONY CONVICTION RELATING TO
19 FRAUD.—Any individual or entity that has been con-
20 victed under Federal or State law, in connection
21 with the delivery of a health care item or service on
22 or after January 1, 1997, or with respect to any act
23 or omission on or after such date in a program oper-
24 ated by or financed in whole or in part by any Fed-
25 eral, State, or local government agency, of a criminal

1 offense consisting of a felony relating to fraud, theft,
2 embezzlement, breach of fiduciary responsibility, or
3 other financial misconduct.”.

4 (2) CONFORMING AMENDMENT.—Section
5 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1))
6 is amended—

7 (A) in the heading, by striking “CONVIC-
8 TION” and inserting “MISDEMEANOR CONVIC-
9 TION”; and

10 (B) by striking “criminal offense” and in-
11 sserting “criminal offense consisting of a mis-
12 demeanor”.

13 (b) ESTABLISHMENT OF MINIMUM PERIOD OF EX-
14 CLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUB-
15 JECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND
16 STATE HEALTH CARE PROGRAMS.—

17 (1) IN GENERAL.—Section 1128(c)(3) of such
18 Act (42 U.S.C. 1320a–7(c)(3)) is amended by add-
19 ing at the end the following new subparagraphs:

20 “(D) In the case of an exclusion of an individual or
21 entity under paragraphs (1), (2), or (3) of subsection (b),
22 the period of exclusion shall be a minimum of 3 years,
23 unless the Secretary determines that an alternative period
24 is appropriate because of aggravating or mitigating cir-
25 cumstances.

1 “(E) In the case of an exclusion of an individual or
 2 entity under paragraph (4) or (5) of subsection (b), the
 3 period of the exclusion shall not be less than the period
 4 during which the individual’s or entity’s license to provide
 5 health care is revoked, suspended, or surrendered, or the
 6 individual or the entity is excluded or suspended from a
 7 Federal or State health care program.

8 “(F) In the case of an exclusion of an individual or
 9 entity under subsection (b)(6)(B), the period of the exclu-
 10 sion shall be not less than 1 year.”.

11 (2) CONFORMING AMENDMENT.—Section
 12 1128(c)(3)(A) of such Act (42 U.S.C. 1320a–
 13 7(c)(3)(A)) is amended by striking “subsection
 14 (b)(12)” and inserting “paragraph (1), (2), (3), (4),
 15 (6)(B), or (12) of subsection (b)”.

16 **SEC. 105. SANCTIONS AGAINST PRACTITIONERS AND PER-**
 17 **SONS FOR FAILURE TO COMPLY WITH STATU-**
 18 **TORY OBLIGATIONS RELATING TO QUALITY**
 19 **OF CARE.**

20 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-
 21 TIONERS AND PERSONS FAILING TO MEET STATUTORY
 22 OBLIGATIONS.—

23 (1) IN GENERAL.—The second sentence of sec-
 24 tion 1156(b)(1) of the Social Security Act (42
 25 U.S.C. 1320c–5(b)(1)) is amended by striking “may

1 prescribe)” and inserting “may prescribe, except
2 that such period may not be less than one year)”.

3 (2) CONFORMING AMENDMENT.—Section
4 1156(b)(2) of such Act (42 U.S.C. 1320c–5(b)(2)) is
5 amended by striking “shall remain” and inserting
6 “shall (subject to the minimum period specified in
7 the second sentence of paragraph (1)) remain”.

8 (b) AMOUNT OF CIVIL MONEY PENALTY.—Section
9 1156(b)(3) of such Act (42 U.S.C. 1320c–5(b)(3)) is
10 amended by striking “the actual or estimated cost” and
11 inserting the following: “\$10,000 for each instance”.

12 (c) REPEAL OF “UNWILLING OR UNABLE” CONDI-
13 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)
14 of such Act (42 U.S.C. 1320c–5(b)(1)) is amended—

15 (1) in the second sentence, by striking “and de-
16 termines” and all that follows through “such obliga-
17 tions,” and

18 (2) by striking the third sentence.

19 **SEC. 106. REVISIONS TO CRIMINAL PENALTIES.**

20 (a) TREBLE DAMAGES FOR CRIMINAL SANCTIONS.—
21 Section 1128B of the Social Security Act (42 U.S.C.
22 1320a–7b) is amended by adding at the end the following
23 new subsection:

24 “(f) In addition to the fines that may be imposed
25 under subsection (a) or (c) any individual found to have

1 violated the provisions of any of such subsections may be
2 subject to treble damages.”.

3 (b) IDENTIFICATION OF COMMUNITY SERVICE OP-
4 PORTUNITIES.—Section 1128B of such Act (42 U.S.C.
5 1320a–7b), as amended by subsection (a), is further
6 amended by adding at the end the following new sub-
7 section:

8 “(g) The Secretary shall—

9 “(1) in consultation with State and local health
10 care officials, identify opportunities for the satisfac-
11 tion of community service obligations that a court
12 may impose upon the conviction of an offense under
13 this section, and

14 “(2) make information concerning such oppor-
15 tunities available to Federal and State law enforce-
16 ment officers and State and local health care offi-
17 cials.”.

18 **SEC. 107. EFFECTIVE DATE.**

19 The amendments made by this subtitle shall take ef-
20 fect January 1, 1997.

1 **Subtitle B—Establishment of All-**
2 **Payer Health Care Fraud and**
3 **Abuse Control Program**

4 **SEC. 111. ALL-PAYER HEALTH CARE FRAUD AND ABUSE**
5 **CONTROL PROGRAM.**

6 (a) IN GENERAL.—Not later than January 1, 1997,
7 the Secretary (acting through the Inspector General of the
8 Department of Health and Human Services) and the At-
9 torney General shall establish a program—

10 (1) to coordinate the functions of the Attorney
11 General, the Secretary, and other organizations with
12 respect to the prevention, detection, and control of
13 health care fraud and abuse,

14 (2)(A) to conduct investigations, audits, evalua-
15 tions, and inspections relating to the delivery of and
16 payment for health care services in the United
17 States which are not subject to investigation, audit,
18 evaluation, and inspection by the Inspector General
19 of another executive department, and (B) to facili-
20 tate the conducting of such investigations, audits,
21 evaluations, and inspections relating to the delivery
22 of and payment for other health care services in the
23 United States, and

1 (3) to facilitate the enforcement of this subtitle
2 and other statutes applicable to health care fraud
3 and abuse.

4 (b) COORDINATION WITH LAW ENFORCEMENT
5 AGENCIES.—In carrying out the program under sub-
6 section (a), the Secretary and Attorney General shall con-
7 sult with, and arrange for the sharing of data and re-
8 sources with Federal, State and local law enforcement
9 agencies, State Medicaid Fraud Control Units, and State
10 agencies responsible for the licensing and certification of
11 health care providers.

12 (c) COORDINATION WITH HEALTH PLANS.—In car-
13 rying out the program under subsection (a), the Secretary
14 and Attorney General shall consult with, and arrange for
15 the sharing of data with representatives of qualified health
16 plans.

17 (d) AUTHORITIES OF ATTORNEY GENERAL AND IN-
18 SPECTOR GENERAL.—In carrying out duties under sub-
19 section (a), the Attorney General and the Inspector Gen-
20 eral are authorized—

21 (1) to conduct, supervise, and coordinate audits,
22 civil and criminal investigations, inspections, and
23 evaluations relating to the program established
24 under such subsection; and

1 (2) to have access (including on-line access as
2 requested and available) to all records available to
3 qualified health plans relating to the activities de-
4 scribed in paragraph (1) (subject to restrictions
5 based on the confidentiality of certain information
6 under section 204(a)).

7 (e) FAILURE TO PROVIDE INFORMATION AS
8 GROUNDS FOR PERMISSIVE EXCLUSION UNDER MEDI-
9 CARE AND MEDICAID.—Section 1128(b)(9) of the Social
10 Security Act (42 U.S.C. 1320a–7(b)(9)) is amended by
11 striking the period at the end and inserting “, or provide
12 any information requested by the Attorney General or the
13 Inspector General of the Department of Health and
14 Human Services to carry out the All-Payer Health Care
15 Fraud and Abuse Control Program established under sec-
16 tion 111 of the Health Care Fraud Prevention and Paper-
17 work Reduction Act of 1995.”;

18 (f) QUALIFIED IMMUNITY FOR PROVIDING INFORMA-
19 TION.—The provisions of section 1157(a) of the Social Se-
20 curity Act (relating to limitation on liability) shall apply
21 to a person providing information or communications to
22 the Secretary or Attorney General in conjunction with
23 their performance of duties under this section, in the same
24 manner as such section applies to information provided

1 to organizations with a contract under part B of title XI
2 of such Act.

3 (g) AUTHORIZATIONS OF APPROPRIATIONS FOR IN-
4 VESTIGATORS AND OTHER PERSONNEL.—In addition to
5 any other amounts authorized to be appropriated to the
6 Secretary and the Attorney General for health care anti-
7 fraud and abuse activities for a fiscal year, there are au-
8 thorized to be appropriated such additional amounts as
9 may be necessary to enable the Secretary and the Attorney
10 General to conduct investigations, audits, evaluations, and
11 inspections of allegations of health care fraud and abuse
12 and otherwise carry out the program established under
13 subsection (a) in a fiscal year.

14 (h) USE OF POWERS UNDER INSPECTOR GENERAL
15 ACT OF 1978.—In carrying out duties and responsibilities
16 under the program established under subsection (a), the
17 Inspector General is authorized to exercise all powers
18 granted under the Inspector General Act of 1978 to the
19 same manner and extent as provided in that Act.

20 (i) DEFINITION.—In this subtitle, the term “Inspec-
21 tor General” means the Inspector General of the Depart-
22 ment of Health and Human Services.

23 **SEC. 112. ESTABLISHMENT OF ALL-PAYER HEALTH CARE**
24 **FRAUD AND ABUSE CONTROL ACCOUNT.**

25 (a) ESTABLISHMENT.—

1 (1) IN GENERAL.—There is hereby created on
2 the books of the Treasury of the United States an
3 account to be known as the “All-Payer Health Care
4 Fraud and Abuse Control Account” (in this section
5 referred to as the “Anti-Fraud Account”). The Anti-
6 Fraud Account shall consist of such gifts and be-
7 quests as may be made as provided in paragraph (2)
8 and such amounts as may be deposited in such Anti-
9 Fraud Account as provided in section 122(d)(2) and
10 title XI of the Social Security Act. It shall also in-
11 clude the following:

12 (A) All criminal fines imposed in cases in-
13 volving a Federal health care offense (as de-
14 fined in subsection (d)).

15 (B) Penalties and damages imposed under
16 the False Claims Act (31 U.S.C. 3729 et seq.),
17 in cases involving claims related to the provision
18 of health care items and services (other than
19 funds awarded to a relator or for restitution).

20 (C) Administrative penalties and assess-
21 ments imposed under titles XI, XVIII, and XIX
22 of the Social Security Act and section 122 (ex-
23 cept as otherwise provided by law).

1 (D) Amounts resulting from the forfeiture
2 of property by reason of a Federal health care
3 offense.

4 (E) Amounts received from the payment of
5 fees to the Secretary of Health and Human
6 Services and the Attorney General under sec-
7 tion 132 by individuals and entities requesting
8 advisory opinions under section 131.

9 Any such funds received on or after the date of the
10 enactment of this Act shall be deposited in the Anti-
11 Fraud Account.

12 (2) AUTHORIZATION TO ACCEPT GIFTS.—The
13 Anti-Fraud Account is authorized to accept on be-
14 half of the United States money gifts and bequests
15 made unconditionally to the Anti-Fraud Account, for
16 the benefit of the Anti-Fraud Account or any activ-
17 ity financed through the Anti-Fraud Account.

18 (3) ADMINISTRATION THROUGH BOARD OF
19 TRUSTEES.—The Anti-Fraud Account shall have a
20 Board of Trustees consisting of the Secretary of
21 Treasury, the Attorney General, the Secretary of
22 Health and Human Services, the Inspector General,
23 and a State Attorney General selected by the Inspec-
24 tor General. The Board of Trustees shall allocate

1 and dispense funds in the Account and generally ad-
2 minister the operations of the Account.

3 (b) USE OF FUNDS.—

4 (1) IN GENERAL.—Amounts in the Anti-Fraud
5 Account shall be available without appropriation and
6 until expended as determined jointly by the Sec-
7 retary and Attorney General in carrying out the All-
8 Payer Health Care Fraud and Abuse Control Pro-
9 gram established under section 111 (including the
10 administration of the Program), and may be used to
11 cover costs incurred in operating the Program, in-
12 cluding—

13 (A) costs of prosecuting health care mat-
14 ters (through criminal, civil and administrative
15 proceedings);

16 (B) costs of investigations (including
17 equipment, salaries, administratively uncontrol-
18 lable work, travel, and training of law enforce-
19 ment personnel);

20 (C) costs of financial and performance au-
21 dits of health care programs and operations;
22 and

23 (D) costs of inspections and other evalua-
24 tions.

1 (2) FUNDS USED TO SUPPLEMENT AGENCY AP-
2 PROPRIATIONS.—It is intended that disbursements
3 made from the Anti-Fraud Account to any Federal
4 agency be used to increase and not supplant the re-
5 cipient agency's appropriated operating budget.

6 (3) USE OF FUNDS FOR EDUCATIONAL ACTIVI-
7 TIES.—Amounts in the Anti-Fraud Account may be
8 used to carry out activities designed to educate pro-
9 viders of health care services about the provisions of
10 this subtitle (and the provisions of law amended by
11 this subtitle).

12 (4) START-UP COSTS OF PROCESS FOR ISSU-
13 ANCE OF ADVISORY OPINIONS.—Amounts in the
14 Anti-Fraud Account may be used to establish the
15 process described in section 131 for the issuance of
16 advisory opinions by the Secretary of Health and
17 Human Services and the Attorney General, but only
18 during the first year for which the process is in op-
19 eration.

20 (c) ANNUAL REPORT.—The Board of Trustees shall
21 submit an annual report to Congress on the amount of
22 revenue which is generated and disbursed by the Anti-
23 Fraud Account in each fiscal year.

1 (d) FEDERAL HEALTH CARE OFFENSE DEFINED.—

2 The term “Federal health care offense” means a violation
3 of, or a criminal conspiracy to violate—

4 (1) sections 226, 668, 1033, or 1347 of title
5 18, United States Code;

6 (2) section 1128B of the Social Security Act;

7 (3) sections 287, 371, 664, 666, 1001, 1027,
8 1341, 1343, or 1954 of title 18, United States Code,
9 if the violation or conspiracy relates to health care
10 fraud;

11 (4) sections 501 or 511 of the Employee Retirement
12 Income Security Act of 1974, if the violation
13 or conspiracy relates to health care fraud; or

14 (5) sections 301, 303(a)(2), or 303(b) or (e) of
15 the Federal Food, Drug and Cosmetic Act, if the
16 violation or conspiracy relates to health care fraud.

17 **Subtitle C—Application of Fraud**
18 **and Abuse Authorities Under**
19 **the Social Security Act to Other**
20 **Payers**

21 **SEC. 121. APPLICATION OF CIVIL MONEY PENALTIES TO**
22 **ALL PAYERS.**

23 (a) ACTIONS SUBJECT TO PENALTY.—Any person
24 who is determined by the Secretary to have committed any
25 of the following actions with respect to a qualified health

1 plan shall be subject to a penalty in accordance with sub-
2 section (b):

3 (1) ACTIONS SUBJECT TO PENALTY UNDER
4 MEDICARE, MEDICAID, AND OTHER SOCIAL SECURITY
5 HEALTH PROGRAMS.—Any action that would subject
6 the person to a penalty under paragraphs (1)
7 through (9) of section 1128A(a) of the Social Secu-
8 rity Act if the action was taken with respect to title
9 V, XVIII, XIX, or XX of such Act.

10 (2) DISCRIMINATING ON BASIS OF MEDICAL
11 CONDITION.—The engagement in any practice that
12 would reasonably be expected to have the effect of
13 denying or discouraging the initial or continued en-
14 rollment in a health plan by individuals whose medi-
15 cal condition or history indicates a need for substan-
16 tial future medical services.

17 (3) INDUCING ENROLLMENT ON FALSE PRE-
18 TENSES.—The engagement in any practice to induce
19 enrollment in a health plan through representations
20 to individuals which the person knows or should
21 know are false or fraudulent.

22 (b) PENALTIES DESCRIBED.—

23 (1) GENERAL RULE.—Any person who the Sec-
24 retary determines has committed an action described
25 in paragraphs (2) through (4) of subsection (a) shall

1 be subject to a civil monetary penalty in an amount
2 not to exceed \$10,000 for each such determination.

3 (2) ACTIONS SUBJECT TO PENALTIES UNDER
4 SOCIAL SECURITY ACT.—In the case of a person who
5 the Secretary determines has committed an action
6 described in paragraph (1) of subsection (a), the
7 person shall be subject to the civil monetary penalty
8 (together with any additional assessment) to which
9 the person would be subject under section 1128A of
10 the Social Security Act if the action on which the
11 determination is based had been committed with re-
12 spect to title V, XVIII, XIX, or XX of such Act.

13 (c) APPLICABILITY OF PROCEDURES UNDER SOCIAL
14 SECURITY ACT.—The provisions of section 1128A of the
15 Social Security Act (other than subsections (a) and (b)
16 and the second sentence of subsection (f)) shall apply to
17 the imposition of a civil monetary penalty or assessment
18 under this section in the same manner as such provisions
19 apply with respect to the imposition of a penalty or assess-
20 ment under section 1128A of such Act.

21 (d) TREATMENT OF AMOUNTS RECOVERED.—Any
22 amounts recovered under this section shall be paid to the
23 Secretary and disposed of as follows:

24 (1) Such portions of the amounts recovered as
25 is determined to have been improperly paid from a

1 qualified health plan for the delivery of or payment
2 for health care items or services shall be repaid to
3 such plan.

4 (2) The remainder of the amounts recovered
5 shall be deposited in the All-Payer Health Care
6 Fraud and Abuse Control Account established under
7 section 112.

8 (e) NOTIFICATION OF LICENSING AUTHORITIES.—
9 Whenever the Secretary's determination to impose a pen-
10 alty or assessment under this section becomes final, the
11 Secretary shall notify the appropriate State or local licens-
12 ing agency or organization (including the agency specified
13 in section 1864(a) and 1902(a)(33) of the Social Security
14 Act) that such a penalty or assessment has become final
15 and the reasons therefore.

16 **SEC. 122. APPLICATION OF CERTAIN CRIMINAL PENALTIES**
17 **TO ALL PAYERS.**

18 Any person who is determined by the Attorney Gen-
19 eral (in consultation with the Secretary) to have commit-
20 ted any action with respect to a qualified health plan that
21 would subject the person to a penalty under subsection
22 (a) or (b) of section 1128B of the Social Security Act if
23 the action was taken with respect to title V, XVIII, XIX,
24 or XX of such Act shall be subject to the penalty (together

1 with any assessment) that would apply if the action was
2 taken with respect to any such title.

3 **SEC. 123. CONSTRUCTION OF SOCIAL SECURITY ACT REF-**
4 **ERENCES.**

5 (a) INCORPORATION OF OTHER AMENDMENTS.—Any
6 reference in this subtitle to a provision of the Social Secu-
7 rity Act shall be considered a reference to the provision
8 as amended under subtitle A.

9 (b) EFFECT OF SUBSEQUENT AMENDMENTS.—Ex-
10 cept as provided in subsection (a), any reference to a pro-
11 vision of the Social Security Act in this subtitle shall be
12 deemed to be a reference to such provision as in effect
13 on the date of the enactment of this Act, and (except as
14 Congress may otherwise provide) any amendments made
15 to such provisions after such date shall not be taken into
16 account in determining the applicability of such provisions
17 to individuals and entities under this Act.

18 **Subtitle D—Advisory Opinions on**
19 **Kickbacks and Self-Referral**

20 **SEC. 131. ESTABLISHMENT OF PROCESS FOR ISSUANCE OF**
21 **ADVISORY OPINIONS.**

22 (a) ESTABLISHMENT.—Not later than 1 year after
23 the date of the enactment of this Act, the Secretary of
24 Health and Human Services (in consultation with the At-
25 torney General) shall establish a process under which indi-

1 individuals and entities may submit a request to the Secretary
2 for an advisory opinion regarding whether any conduct of
3 the individual or entity—

4 (1) constitutes grounds for the imposition of a
5 sanction under section 1128B(b) (relating to kick-
6 backs, bribes, and rebates) of the Social Security
7 Act or under subtitle C through the application of
8 such section; or

9 (2) would result in the denial of payment for a
10 service furnished by the individual or entity, or the
11 imposition of a civil money penalty, on the basis de-
12 scribed in section 1877 of the Social Security Act.

13 (b) DEADLINE FOR RESPONSE.—The Secretary of
14 Health and Human Services shall respond to a request
15 for an advisory opinion submitted under subsection (a) not
16 later than 90 days after receiving the request.

17 (c) OPINIONS LIMITED TO QUESTIONS OF FACT.—
18 An advisory opinion issued under subsection (a) may only
19 respond to the facts presented by the individual or entity
20 requesting the advisory opinion.

21 (d) ISSUANCE OF REGULATIONS.—The Secretary
22 may issue such regulations as the Secretary considers ap-
23 propriate to carry out this subtitle, including regulations
24 concerning the process under which individuals and enti-

1 ties submit and the Secretary responds to requests for ad-
 2 visory opinions.

3 **SEC. 132. IMPOSITION OF FEES.**

4 (a) IN GENERAL.—The Secretary of Health and
 5 Human Services and the Attorney General shall require
 6 an individual or entity requesting an advisory opinion
 7 under section 131 to submit a fee.

8 (b) AMOUNT.—The amount of the fee required under
 9 subsection (a) shall be equal to the costs incurred by the
 10 Secretary and the Attorney General in responding to the
 11 request.

12 **Subtitle E—Preemption of State**
 13 **Corporate Practice Laws**

14 **SEC. 141. PREEMPTION OF STATE LAWS PROHIBITING COR-**
 15 **PORATE PRACTICE OF MEDICINE.**

16 No provision of State or local law shall apply that
 17 prohibits a corporation from practicing medicine.

18 **TITLE II—INFORMATION SYS-**
 19 **TEMS AND ADMINISTRATIVE**
 20 **SIMPLIFICATION**

21 **SEC. 201. REQUIREMENT FOR HEALTH BENEFIT CARDS.**

22 (a) HEALTH BENEFIT CARDS.—

23 (1) REQUIREMENT.—Each health benefit plan
 24 sponsor shall issue a health benefit card that meets
 25 the requirements of subsection (c) for each individ-

1 ual who is entitled to benefits under a health benefit
2 plan provided or sponsored by the sponsor.

3 (2) DEADLINE FOR APPLICATION OF REQUIRE-
4 MENT.—The deadline specified under this paragraph
5 for the requirement under paragraph (1) is 12
6 months after the date the standards are established
7 under subsection (c).

8 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
9 ALTIES.—

10 (1) IN GENERAL.—In the case of a health bene-
11 fit plan sponsor that fails to issue a health benefit
12 card in accordance with subsection (a)(1), the spon-
13 sor is subject to a civil money penalty not to exceed
14 \$100 for each such violation. The provisions of sec-
15 tion 1128A of the Social Security Act (other than
16 subsections (a) and (b)) shall apply to a civil money
17 penalty under this subsection in the same manner as
18 such provisions apply to a penalty or proceeding
19 under section 1128A(a) of such Act.

20 (2) EFFECTIVE DATE.—No penalty may be im-
21 posed under paragraph (1) for any failure occurring
22 before the deadline specified in subsection (a)(2).

23 (c) HEALTH BENEFIT CARDS.—

24 (1) IN GENERAL.—The Secretary shall establish
25 standards consistent with this subsection respecting

1 the form and information to be contained on health
2 benefit cards (for purposes of subsection (a)).

3 (2) ELECTRONIC.—

4 (A) IN GENERAL.—Subject to subpara-
5 graph (B), the card shall be in a form similar
6 to that of a credit card and shall have, encoded
7 in electronic form—

8 (i) the identity of the individual enti-
9 tled to health benefits;

10 (ii) the health benefit plan in which
11 the individual is enrolled;

12 (iii) the identity of each principal in-
13 sured (as defined by the Secretary) for the
14 family that includes the individual, in the
15 case of an individual who is enrolled under
16 a family class of enrollment;

17 (iv) the telephone number or numbers
18 to be used for the submission electronically
19 of claims under the plan under section
20 203; and

21 (v) information relating to organ do-
22 nation.

23 (B) USE OF ELECTRONIC READ-AND-
24 WRITE CARDS.—The Secretary may provide for
25 cards in an electronic form that permits infor-

1 mation on the card to be readily changed. Such
2 information may include information relating to
3 the health coverage status of the individual and
4 the medical history of the individual.

5 (C) PERSONAL IDENTIFIER.—For pur-
6 poses of subparagraph (A) and for purposes of
7 claims processing and related purposes under
8 section 203, the Social Security account number
9 of the individual or, in the case of an infant or
10 other individual to whom such a number has
11 not been issued, such a Social Security account
12 number of a parent or guardian or other num-
13 ber as the Secretary shall specify, shall be used
14 as the personal identifier for the individual.

15 (3) ADDITIONAL INFORMATION.—The card
16 shall include such additional information, in elec-
17 tronic or other form, as the Secretary may require
18 to carry out the purposes of this Act. In addition,
19 the health benefit plan sponsor issuing the card may
20 include such additional information on the card as
21 the sponsor desires, subject to such limitations as
22 the Secretary may provide.

23 (4) PERMISSIBLE USES OF CARD.—A health
24 benefit card that is issued to an individual who is
25 entitled to benefits under a health benefit plan may

1 be used by an individual or entity only for the pur-
2 pose of providing or assisting the individual entitled
3 to benefits in obtaining an item or service that is
4 covered under such plan.

5 (5) DEADLINE.—The Secretary shall first es-
6 tablish the standards for health benefit cards under
7 this subsection by not later than 18 months after
8 the date of the enactment of this Act.

9 (d) APPLICATION TO MEDICARE AND MEDICAID PRO-
10 GRAM.—

11 (1) MEDICARE PROGRAM.—The Secretary shall
12 provide, in regulations promulgated to carry out the
13 medicare program, that identification cards issued
14 under that program are modified to the extent re-
15 quired to conform to the standards established under
16 subsection (c), by not later than the deadline speci-
17 fied in subsection (a)(2).

18 (2) STATE MEDICAID PLANS.—As a condition
19 for the approval of a State plan under the medicaid
20 program, effective for calendar quarters beginning
21 on or after the deadline specified in subsection
22 (a)(2), each such plan shall provide, in accordance
23 with regulations of the Secretary, that identification
24 cards issued under the plan are modified to the ex-
25 tent required to conform to subsection (c).

1 **SEC. 202. NATIONAL ENROLLMENT VERIFICATION SYSTEM.**

2 (a) ESTABLISHMENT.—The Secretary shall establish
3 a national enrollment verification system for the verifica-
4 tion of an individual's enrollment in a health benefit plan
5 and entitlement to benefits under such plan. The system
6 shall assist in the identification of, and collection from,
7 parties responsible for the payment for health care items
8 and services furnished to individuals enrolled under a
9 health benefit plan.

10 (b) INFORMATION IN SYSTEM.—The enrollment ver-
11 ification system shall contain such information submitted
12 by health benefit plan sponsors, employers, and other indi-
13 viduals and entities specified by the Secretary as the Sec-
14 retary shall determine in standards established under this
15 section. The information shall include the following with
16 respect to each individual enrolled in a health benefit plan
17 (regardless of whether the individual is enrolled under an
18 individual or a family class of enrollment):

19 (1) The name, address, and personal identifier
20 of the individual and the identity of each principal
21 insured (as defined by the Secretary under section
22 201(c)(2)(A)(iii)) for the family that includes the in-
23 dividual, in the case of an individual who is enrolled
24 under a family class of enrollment.

1 (2) The name, address, and telephone number
2 of each health benefit plan in which the individual
3 is enrolled.

4 (3) The type of coverage elected.

5 (4) Race and ethnicity data.

6 (5) The period for which such coverage is elect-
7 ed.

8 (6) The status of individuals with respect to
9 deductibles, copayments, coinsurance, or out-of-pock-
10 et limits on cost sharing.

11 (7) Coordination of benefit information appro-
12 priate in determining liability in cases in which bene-
13 fits may be payable under 2 or more health benefit
14 plans.

15 (c) PERIODICITY OF SUBMISSIONS.—The standards
16 established by the Secretary under this subsection shall
17 require the submission of information to the national en-
18 rollment verification system on a periodic basis (as deter-
19 mined by the Secretary) in order to report applicable
20 changes with respect to enrollment status or eligibility.

21 (d) FORM OF INQUIRY.—The verification system
22 shall be capable of accepting inquiries from health care
23 providers, health benefit plan sponsors (and any other in-
24 dividual or entity determined appropriate by the Sec-

1 retary) in a variety of electronic and other forms, includ-
2 ing—

3 (1) through electronic transmission of informa-
4 tion on the health benefit card (in a manner similar
5 to that for verification of credit card purchases);

6 (2) through the use of a touch-tone telephone
7 line; and

8 (3) through the use of a computer modem.

9 (e) FORM OF RESPONSE.—The system shall be capa-
10 ble of responding to inquiries under subsection (d) in a
11 variety of electronic and other forms, including—

12 (1) through modem transmission of informa-
13 tion;

14 (2) through computer synthesized voice commu-
15 nication; and

16 (3) through transmission of information to a
17 facsimile (fax) machine.

18 (f) LIMITS ON DISCLOSURE OF INFORMATION RE-
19 PORTED.—The disclosure of information reported to the
20 national enrollment verification system shall be restricted
21 by the Secretary under standards established by the Sec-
22 retary.

23 (g) FEES.—The Secretary may impose a fee for the
24 acceptance of, or response to, an inquiry to the verification
25 system.

1 (h) PUBLIC DOMAIN SOFTWARE TO PROVIDERS.—

2 The Secretary shall provide for the development, and shall
3 make available without charge to health care providers,
4 such computer software as will enable such providers to
5 make inquiries to, and receive responses from, the national
6 enrollment verification system in electronic form.

7 (i) DEADLINE.—The Secretary shall establish the
8 system and standards under this section (and shall develop
9 and make available the software under subsection (h)) by
10 not later than 12 months after the date of the enactment
11 of this Act.

12 (j) CIVIL MONEY PENALTY.—In the case of a failure
13 of an individual or entity to report information to the en-
14 rollment verification system under a standard established
15 by the Secretary under this section, the individual or en-
16 tity shall be subject, in addition to any other penalties that
17 may be prescribed by law, to a civil money penalty of not
18 more than \$100 for each day in which such failure per-
19 sists. The provisions of section 1128A of the Social Secu-
20 rity Act (other than subsections (a) and (b)) shall apply
21 to a civil money penalty under this subsection in the same
22 manner as such provisions apply to a penalty or proceed-
23 ing under section 1128A(a) of such Act.

24 (k) ELIMINATION OF EMPLOYER REQUIREMENT TO
25 REPORT CERTAIN INFORMATION TO MEDICARE AND

1 MEDICAID COVERAGE DATA BANK.—Effective upon full
2 implementation of the national enrollment verification sys-
3 tem under this section—

4 (1) no employer is required to make any reports
5 under section 1144(c) of the Social Security Act;
6 and

7 (2) information and functions previously in or
8 performed by the Medicare and Medicaid Coverage
9 Data Bank under section 1144 of such Act shall be
10 subsumed by the enrollment verification system.

11 **SEC. 203. REQUIREMENTS FOR UNIFORM CLAIMS AND**
12 **ELECTRONIC CLAIMS DATA SET.**

13 (a) REQUIREMENTS.—

14 (1) SUBMISSION OF CLAIMS.—Each health care
15 provider that furnishes services in the United States
16 for which payment may be made under a health ben-
17 efit plan shall submit any claim for payment for
18 such services only in a form and manner consistent
19 with the standards established under subsection (c).

20 (2) ACCEPTANCE OF CLAIMS.—A health benefit
21 plan sponsor may not reject a claim for payment
22 under the health benefit plan provided on the basis
23 of the form or manner in which the claim is submit-
24 ted if the claim is submitted in accordance with the
25 standards established under subsection (c).

1 (3) EFFECTIVE DATE.—This subsection shall
2 apply to claims for services furnished on or after the
3 date that is 6 months after the date standards are
4 established under subsection (c).

5 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
6 ALTIES.—

7 (1) IN GENERAL.—

8 (A) PROVIDERS.—In the case of a health
9 care provider that submits a claim in violation
10 of subsection (a)(1), the provider is subject to
11 a civil money penalty of not to exceed \$100 (or,
12 if greater, the amount of the claim) for each
13 such violation.

14 (B) HEALTH BENEFIT PLAN SPONSORS.—
15 In the case of a health benefit plan sponsor
16 that rejects a claim in violation of subsection
17 (a)(2), the sponsor is subject to a civil money
18 penalty of not to exceed \$100 (or, if greater,
19 the amount of the claim) for each such viola-
20 tion.

21 (2) PROCESS.—The provisions of section 1128A
22 of the Social Security Act (other than subsections
23 (a) and (b)) shall apply to a civil money penalty
24 under paragraph (1) in the same manner as such

1 provisions apply to a penalty or proceeding under
2 section 1128A(a) of such Act.

3 (c) STANDARDS RELATING TO UNIFORM CLAIMS AND
4 ELECTRONIC CLAIMS DATA SET.—

5 (1) ESTABLISHMENT OF STANDARDS.—The
6 Secretary shall establish standards that relate to the
7 form and manner of submission of claims for bene-
8 fits under a health benefit plan. The standards—

9 (A) shall require that such claims be sub-
10 mitted electronically;

11 (B) shall define the data elements to be
12 contained in a uniform electronic claims data
13 set to be used with respect to such claims;

14 (C) establish a uniform electronic format
15 for the electronic transmission of such elements;

16 (D) shall include instructions on record
17 keeping in support of claims submitted; and

18 (E) shall ensure the suitability of elec-
19 tronic data as evidence in a court of law.

20 (2) SCOPE OF INFORMATION.—

21 (A) IN GENERAL.—The standards under
22 this subsection are intended to cover substan-
23 tially most claims that are filed under health
24 benefit plans. Such information need not in-
25 clude all elements that may potentially be re-

1 required to be reported under utilization review
2 provisions of plans.

3 (B) ENSURING ACCOUNTABILITY FOR
4 CLAIMS SUBMITTED ELECTRONICALLY.—In es-
5 tablishing such standards, the Secretary, in
6 consultation with appropriate agencies, shall in-
7 clude such methods of ensuring provider re-
8 sponsibility and accountability for claims sub-
9 mitted electronically that are designed to con-
10 trol fraud and abuse in the submission of such
11 claims.

12 (C) COMPONENTS.—In establishing such
13 standards the Secretary shall—

14 (i) with respect to data elements, de-
15 fine data fields, formats, and medical no-
16 menclature, and plan benefit and insurance
17 information; and

18 (ii) develop a single, uniform, up-to-
19 date coding system for procedures, serv-
20 ices, and diagnoses based, to the maximum
21 extent possible, on the American Medical
22 Association's Common Procedural Termi-
23 nology, Fourth Edition or a revised version
24 of such text (with respect to procedures
25 and services) and the International Classi-

1 fication of Diseases, 9th Revision, Clinical
2 Modification, Third Edition or a revised
3 version of such text (with respect to diag-
4 noses), with additional coding developed as
5 necessary by the Secretary.

6 (3) COORDINATION WITH STANDARDS FOR
7 ELECTRONIC MEDICAL RECORDS.—In establishing
8 standards under this subsection, the Secretary shall
9 assure that—

10 (A) the development of such standards is
11 coordinated with the development of the stand-
12 ards for reporting uniform clinical data sets
13 under section 204; and

14 (B) the coding of data elements under the
15 uniform electronic claims data set and the cod-
16 ing of the same elements in the uniform hos-
17 pital clinical data set and the uniform patient
18 information data set developed under section
19 204 are consistent.

20 (4) UNIFORM, UNIQUE PROVIDER IDENTIFICA-
21 TION CODES.—In establishing standards under this
22 subsection—

23 (A) the Secretary shall provide for a
24 unique identifier code for each health care pro-
25 vider and group practice that furnishes services

1 for which a claim may be submitted under a
2 health benefit plan; and

3 (B) in the case of a provider that has a
4 unique identifier issued for purposes of the
5 medicare program, the code provided under
6 subparagraph (A) shall be the same as such
7 unique identifier.

8 (5) PUBLIC DOMAIN SOFTWARE TO PROVID-
9 ERS.—The Secretary shall provide for the develop-
10 ment, and shall make available without charge to
11 health care providers, such computer software as will
12 enable the providers to submit claims and to receive
13 verification of claims status electronically.

14 (6) STANDARDS FOR CLAIMS FOR CLINICAL
15 LABORATORY TESTS.—The standards shall provide
16 that claims for clinical laboratory tests for which
17 benefits are provided under a health benefit plan
18 shall be submitted directly by the person or entity
19 that performed (or supervised the performance of)
20 the tests to the plan in a manner consistent with
21 (and subject to such exceptions as are provided
22 under) the requirement for direct submission of such
23 claims under the medicare program.

24 (7) DEADLINE.—The Secretary shall first pro-
25 vide for the standards for the uniform claims under

1 this subsection (and shall develop and make avail-
2 able the software under paragraph (6)) by not later
3 than 1 year after the date of the enactment of this
4 Act.

5 (d) USE UNDER MEDICARE AND MEDICAID PRO-
6 GRAMS.—

7 (1) REQUIREMENT FOR PROVIDERS.—In the
8 case of a health care provider that submits a claim
9 for services furnished under the medicare program
10 or medicaid program in violation of subsection
11 (a)(1), no payment shall be made under such pro-
12 gram for such services.

13 (2) REQUIREMENTS OF INTERMEDIARIES AND
14 CARRIERS UNDER MEDICARE PROGRAM.—The Sec-
15 retary shall provide, in regulations promulgated to
16 carry out title XVIII of the Social Security Act, that
17 the claims process provided under that title is modi-
18 fied to the extent required to conform to the stand-
19 ards established under subsection (c).

20 (3) REQUIREMENTS OF STATE MEDICAID
21 PLANS.—As a condition for the approval of State
22 plans under the medicaid program, effective as of
23 the effective date specified in subsection (a)(3), each
24 such plan shall provide, in accordance with regula-
25 tions of the Secretary, that the claims process pro-

1 vided under the plan is modified to the extent re-
2 quired to conform to the standards established under
3 subsection (c).

4 **SEC. 204. REPORTING OF UNIFORM CLINICAL DATA SETS.**

5 (a) STANDARDS FOR ELECTRONIC REPORTING OF
6 UNIFORM CLINICAL DATA SETS.—

7 (1) PROMULGATION OF STANDARDS.—

8 (A) IN GENERAL.—Not later than the
9 deadlines provided in paragraph (5), the Sec-
10 retary shall promulgate standards described in
11 paragraph (2) concerning the uniform clinical
12 data sets described in such paragraph.

13 (B) REVISION.—The Secretary may from
14 time to time revise the standards promulgated
15 under this paragraph.

16 (2) CONTENTS OF STANDARDS.—The standards
17 promulgated under paragraph (1) shall include at
18 least the following:

19 (A) A definition of a uniform hospital clini-
20 cal data set, including a definition of the set of
21 comprehensive data elements, for use by utiliza-
22 tion and quality control peer review organiza-
23 tions.

24 (B) A definition of a uniform patient infor-
25 mation data set including data obtained at the

1 point of care, for use by utilization and quality
2 control peer review organizations with respect
3 to physician care.

4 (C) A specification of, and manner of pres-
5 entation of, the individual data elements of the
6 sets under this paragraph.

7 (D) Standards concerning the electronic
8 transmission of such data sets.

9 (E) Standards relating to confidentiality of
10 health information reported under this section,
11 which include the physical security of electronic
12 data and the use of keys, passwords,
13 encryption, and other means to ensure the pro-
14 tection of the confidentiality and privacy of
15 electronic data.

16 (F) Standards to ensure the suitability of
17 electronic data as evidence in a court of law.

18 (3) COORDINATION WITH STANDARDS FOR UNI-
19 FORM ELECTRONIC CLAIMS DATA SET.—In establish-
20 ing standards under this subsection, the Secretary
21 shall ensure that—

22 (A) the development of the standards is co-
23 ordinated with the development of the stand-
24 ards for the uniform electronic claims data set
25 under section 203;

1 (B) the coding of the same data elements
2 under the uniform hospital clinical data set, the
3 uniform patient information data set, and the
4 uniform electronic claims data set is consistent;
5 and

6 (C) the standards under this subsection
7 are consistent, to the maximum extent prac-
8 ticable, with other standards existing at the
9 time the standards under this subsection are es-
10 tablished, including any standard set by the
11 American National Standards Institute.

12 (4) CONSULTATION.—in establishing standards
13 under this subsection, the Secretary shall—

14 (A) consult with the American National
15 Standards Institute, health care providers,
16 health benefit plan sponsors, and other inter-
17 ested parties; and

18 (B) take into consideration the data set
19 used by the utilization and quality control peer
20 review program under part B of title XI of the
21 Social Security Act.

22 (5) DEADLINES.—The Secretary shall promul-
23 gate standards described in paragraph (2) concern-
24 ing the uniform hospital clinical data set prior to the
25 expiration of the 1-year period beginning on the date

1 of the enactment of this Act. The Secretary shall
2 promulgate standards described in paragraph (2)
3 concerning the uniform patient information clinical
4 data set prior to January 1, 2001.

5 (b) REQUIREMENT FOR APPLICATION OF ELEC-
6 TRONIC RECORDS STANDARDS TO HOSPITALS.—

7 (1) AS CONDITION OF MEDICARE PARTICIPA-
8 TION.—As of January 1, 2001, each hospital, as a
9 requirement of each participation agreement under
10 section 1866 of the Social Security Act, shall, in ac-
11 cordance with the standards promulgated under sub-
12 section (a)(1)—

13 (A) maintain clinical data included in the
14 uniform hospital clinical data set under sub-
15 section (a)(2)(A) in electronic form on all inpa-
16 tients;

17 (B) upon request of the Secretary or of a
18 utilization and quality control peer review orga-
19 nization (with which the Secretary has entered
20 into a contract under part B of title XI of such
21 Act), transmit electronically data requested
22 from such data set; and

23 (C) upon request of the Secretary, or of a
24 fiscal intermediary or carrier, transmit elec-

1 tronically any data (with respect to a claim)
2 from such data set.

3 (2) APPLICATION OF PRESENTATION AND
4 TRANSMISSION STANDARDS TO ELECTRONIC TRANS-
5 MISSION TO FEDERAL AGENCIES.—Effective Janu-
6 ary 1, 2001, if a hospital is required under a Fed-
7 eral program to transmit a data element included in
8 the uniform hospital clinical data set that is subject
9 to a standard, promulgated under subsection (a)(1),
10 described in subparagraph (C) or (D) of subsection
11 (a)(2), the head of the Federal agency responsible
12 for such program (if not otherwise authorized) is au-
13 thorized to require the provider to present and
14 transmit the data element electronically in accord-
15 ance with such a standard.

16 (c) LIMITATION ON DATA REQUIREMENTS WHERE
17 STANDARDS IN EFFECT.—

18 (1) IN GENERAL.—On or after January 1,
19 2001, a health benefit plan sponsor may not require,
20 for the purpose of utilization review or as a condi-
21 tion of providing benefits or making payments under
22 the plan provided, that a hospital—

23 (A) provide any data element not in the
24 uniform hospital clinical data set specified

1 under the standards promulgated under sub-
2 section (a); or

3 (B) transmit or present any such data ele-
4 ment in a manner inconsistent with such stand-
5 ards applicable to such transmission or presen-
6 tation.

7 (2) COMPLIANCE.—The Secretary may impose
8 a civil money penalty on any health benefit plan
9 sponsor that fails to comply with paragraph (1) in
10 an amount not to exceed \$100 for each such failure.
11 The provisions of section 1128A of the Social Secu-
12 rity Act (other than the first sentence of subsection
13 (a) and other than subsection (b)) shall apply to a
14 civil money penalty under this paragraph in the
15 same manner as such provisions apply to a penalty
16 or proceeding under section 1128A(a) of such Act.

17 (3) APPLICATION TO MEDICARE PROGRAM.—Ef-
18 fective as of January 1, 2001, neither the Secretary,
19 nor any carrier or fiscal intermediary, nor any utili-
20 zation and quality control peer review organization
21 may require, for the purpose of utilization review or
22 as a condition of providing benefits or making pay-
23 ments under the medicare program, that a hos-
24 pital—

1 (A) provide any data element not in the
2 uniform hospital clinical data set specified
3 under the standards promulgated under sub-
4 section (a); or

5 (B) transmit or present any such data ele-
6 ment in a manner inconsistent with such stand-
7 ards applicable to such transmission or presen-
8 tation.

9 (4) APPLICATION TO MEDICAID PROGRAM.—As
10 a condition for the approval of State plans under the
11 medicaid program and in accordance with regula-
12 tions of the Secretary, effective as of January 1,
13 2001, each such plan may not require that a hos-
14 pital, for the purpose of utilization review or as a
15 condition of providing benefits or making payments
16 under the plan—

17 (A) provide any data element not in the
18 uniform hospital clinical data set specified
19 under the standards promulgated under sub-
20 section (a), or

21 (B) transmit or present any such data ele-
22 ment in a manner inconsistent with such stand-
23 ards applicable to such transmission or presen-
24 tation.

25 (d) PREEMPTION OF STATE QUILL PEN LAWS.—

1 (1) IN GENERAL.—Any provision of State law
2 that requires medical or health insurance records
3 (including billing information) to be maintained in
4 written, rather than electronic, form is deemed to be
5 satisfied if the records are maintained in an elec-
6 tronic form that meets standards established by the
7 Secretary under paragraph (2).

8 (2) SECRETARIAL AUTHORITY.—Not later than
9 1 year after the date of the enactment of this Act,
10 the Secretary shall issue regulations to carry out
11 paragraph (1). The regulations shall provide for an
12 electronic substitute that is in the form of a unique
13 identifier (assigned to each authorized individual)
14 that serves the functional equivalent of a signature.
15 The regulations may provide for such exceptions to
16 paragraph (1) as the Secretary determines to be nec-
17 essary to prevent fraud and abuse, to prevent the il-
18 legal distribution of controlled substances, and in
19 such other cases as the Secretary deems appropriate.

20 (3) EFFECTIVE DATE.—Paragraph (1) shall
21 take effect on the first day of the first month that
22 begins more than 30 days after the date the Sec-
23 retary issues the regulations referred to in para-
24 graph (2).

1 **SEC. 205. UNIFORM HOSPITAL COST REPORTING.**

2 Each hospital, as a requirement under a participation
3 agreement under section 1866(a) of the Social Security
4 Act for each cost reporting period beginning during or
5 after fiscal year 1996, shall provide for the reporting of
6 information to the Secretary with respect to any hospital
7 care provided in a uniform manner consistent with stand-
8 ards established by the Secretary to carry out section
9 4007(c) of the Omnibus Budget Reconciliation Act of
10 1987 and in an electronic form consistent with standards
11 established by the Secretary.

12 **SEC. 206. USE OF TASK FORCES.**

13 In adopting standards under this title, the Sec-
14 retary—

15 (1) shall take into account the recommenda-
16 tions of—

17 (A) current task forces, including at least
18 the Workgroup on Electronic Data Interchange,
19 National Uniform Billing Committee, the Uni-
20 form Claim Task Force, and the Computer-
21 based Patient Record Institute; and

22 (B) national organizations representing
23 health care financial managers; and

24 (2) shall provide that electronic transmission
25 standards are consistent, to the extent practicable,
26 with the applicable standards established by the Ac-

- 1 credited Standards Committee X-12 of the Amer-
2 ican National Standards Institute.



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